

**Memorandum**

Date MAR 20 2000

From June Gibbs Brown  
Inspector General *June G Brown*

Subject Six-State Review of Outpatient Rehabilitation Facilities (A-04-99-01193)

To Nancy-Ann Min DeParle  
Administrator  
Health Care Financing Administration

Attached are two copies of our final report entitled, "Six-State Review of Outpatient Rehabilitation Facilities." The objective of this review was to determine whether outpatient physical therapy, occupational therapy, and speech pathology services were provided and billed in accordance with Medicare eligibility and reimbursement requirements. Our work was supported by the Health Care Financing Administration (HCFA). We are grateful for the assistance provided to the Office of Inspector General by the highly professional HCFA staff at both the central and regional offices.

We estimate that for the 12-month period ended June 30, 1998, Medicare fiscal intermediaries (FI) paid outpatient rehabilitation facilities (ORF), in the six States reviewed, \$173 million for unallowable or highly questionable ORF services. The ORFs in these six States--Florida, Louisiana, Michigan, New Jersey, Pennsylvania, and Texas--accounted for \$277 million (about 50 percent) of the total ORF payments nationwide of \$572 million during Calendar Year 1997.

Medicare pays for outpatient physical therapy, occupational therapy, and speech pathology services that are reasonable and necessary for the treatment of an individual's illness or injury. However, we found that Medicare paid for ORF services to beneficiaries: (1) who exhibited no functional impairment; (2) who evidenced no active participation with the therapist; and/or (3) who had no expectation for significant improvement within a reasonable and predictable length of time.

From the ORFs in the 6 States, we statistically selected 200 claims for review of which 108 claims (54 percent) containing 843 units of service (55 percent of the services) were found to involve unallowable or highly questionable services.

We believe that Medicare made payments to ORFs for unallowable or highly questionable services because, in part, there was no review process for new ORF providers which included an evaluation of whether the services provided to beneficiaries met Medicare requirements. The HCFA contracts with each State's survey agency to conduct an on-site

survey of ORFs which submit an application to be a Medicare provider. If approved, the applicant is issued a Medicare provider number. The intent of the survey is to ensure that the facilities are in compliance with the Medicare conditions of participation for providers of outpatient physical therapy, occupational therapy, and speech pathology services. However, this process focuses only on whether or not the facility meets applicable health and safety standards, whether the staff is properly licensed to render therapy, and whether the existing medical records contain the required documentation. The survey is not designed to include a medical review of the clinical records to determine the appropriateness (i.e., medical necessity) of the services rendered.

Furthermore, an ORF is required to have one primary Medicare-certified location that is adequately staffed and equipped to treat patients. Our review showed that many providers have opened satellite facilities, or extension units, to render services within assisted living facilities or skilled nursing facilities. The HCFA does not require these units to be surveyed by the State agency. In addition, there is no requirement that the originally-certified site undergo any periodic re-certification. Essentially, once an ORF is granted participation in the Medicare program, there is minimal accountability that it - or its extension units - remain compliant with Medicare requirements.

Lastly, we believe that FI medical review activities of outpatient rehabilitation services provided by ORFs need to be expanded to identify claims for beneficiaries whose conditions were inappropriate for treatment or who would not benefit from the services.

Based on the results of our review, we recommended that HCFA:

- Consider implementing a review process for new providers to include an evaluation of whether the services provided to beneficiaries meet Medicare requirements.
- Consider a periodic re-certification requirement for ORFs to determine whether or not the facilities remain compliant with Federal and State laws and regulations.
- Instruct FIs to recover the specific overpayments we identified as part of our sample and review all other claims submitted by the ORFs for the beneficiaries in our sample to identify and recover additional overpayments.
- Require FIs to provide in-house educational services to new providers to inform them about Medicare coverage, billing, and reimbursement requirements.

- Require FIs to conduct a pre-payment medical review of claims submitted by new providers to determine the appropriateness of the services rendered.
- Require FIs to intensify medical review of claims submitted by ORFs.

In its written response to our draft report, HCFA concurred with our specific recommendations. The HCFA stated that it has been aware of the potential for abuse in the provision of therapy services in Comprehensive Outpatient Rehabilitation Facilities (CORF) and ORFs and has taken steps to reduce Medicare vulnerability. Currently, many HCFA contractors place new therapy providers on some level of intensified review, and therapy providers have been included in special focus reviews for several years.

As part of its comprehensive plan for program integrity, HCFA developed an action plan to deal with the vulnerabilities of ORFs and CORFs. The action plan presents both short- and long-term interventions. Short-term approaches to improve high claim error rates as well as a geographical concentration of providers, include an intensified, targeted, and progressive medical review strategy and educational interventions. An independent program safeguard contractor task order will be developed to address the problems of a lack of re-certification surveys by State agencies and the proliferation of off-site locations. Long-term activities include the use of the pending regulation that establishes and maintains provider billing privileges to more closely monitor new and existing providers and a comprehensive review of the benefit and regulations by several HCFA components.

We believe HCFA's action plan, when fully implemented, should help to ensure the integrity of Medicare payments for this benefit. The complete text of HCFA's response is presented as APPENDIX D to this report.

Please advise us within 60 days on the status of actions taken or planned on our recommendations. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-04-99-01193 in all correspondence relating to this report.

Attachment

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**SIX-STATE REVIEW OF  
OUTPATIENT REHABILITATION  
FACILITIES**



**JUNE GIBBS BROWN**  
**Inspector General**

**MARCH 2000**  
**A-04-99-01193**

**Memorandum**

Date MAR 20 2000

From June Gibbs Brown  
Inspector General *June G Brown*

Subject Six State Review of Outpatient Rehabilitation Facilities (A-04-99-01193)

To Nancy-Ann Min DeParle  
Administrator  
Health Care Financing Administration

This final report provides you with the results of our review of Medicare outpatient rehabilitation facilities (ORF) in six States for the 12-month period ended June 30, 1998. The ORFs in these six States--Florida, Louisiana, Michigan, New Jersey, Pennsylvania, and Texas--accounted for about 50 percent of the total ORF payments nationwide during Calendar Year (CY) 1997.

The objective of this review was to determine whether outpatient physical therapy, occupational therapy, and speech pathology services were provided and billed in accordance with Medicare eligibility and reimbursement requirements.

**The OIG estimates Medicare paid \$173 million for unallowable and highly questionable outpatient rehabilitation services.**

Our work was supported by the Health Care Financing Administration (HCFA). We are grateful for the assistance provided to the Office of Inspector General (OIG) by the highly professional HCFA staff at both the central and regional offices.

From the ORFs in the 6 States, we statistically selected 200 claims for review containing 1,475 units of physical therapy, occupational therapy, and speech pathology services. Of these, 108 claims (54 percent) containing 843 units of service (54.7 percent of the services)<sup>1</sup> were found to involve unallowable or highly questionable services.

Of the 200 claims statistically selected, we medically reviewed 192 claims containing 1,397 units of service and found that 102 claims containing 782 units did not meet Medicare eligibility and reimbursement requirements. In the opinion of expert medical reviewers:

- 567 units of service contained in 66 claims were not reasonable and necessary for the patient's condition.

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<sup>1</sup>The percentage was calculated using cluster methodology, where a claim represents a cluster of units of service.

- 215 units of service contained in 36 claims were inadequately documented, or missing required documentation.

The remaining 8 claims from 8 providers, containing 78 units of service, were not reviewed by medical experts because the providers were either suspended or terminated from the Medicare program, unable to produce any medical record for the beneficiary, or no longer operational and could not be located. Although we could not complete our review of these claims, six of these providers were either suspended or terminated from the Medicare program or were unable to produce any medical record for the beneficiary. In accordance with our sampling methodology, the claims from these six providers were considered errors. The claims from the other two providers, which were no longer operational or could not be located, were not considered errors.

We estimate that for the 12-month period ended June 30, 1998, Medicare fiscal intermediaries (FI) paid ORFs, in the six States reviewed, \$173 million for unallowable or highly questionable ORF services.

Medicare pays for outpatient physical therapy, occupational therapy, and speech pathology services that are reasonable and necessary for the treatment of an individual's illness or injury. However, we found that Medicare paid for ORF services to beneficiaries: (1) who exhibited no functional impairment; (2) who evidenced no active participation with the therapist; and/or (3) who had no expectation for significant improvement within a reasonable and predictable length of time.

We believe that Medicare made payments to ORFs for unallowable or highly questionable services because, in part, there was no review process for new ORF providers which included an evaluation of whether the services provided to beneficiaries met Medicare requirements. The HCFA contracts with each State's survey agency to conduct an on-site survey of ORFs which submit an application to be a Medicare provider. If approved, the applicant is issued a Medicare provider number. The intent of the survey is to ensure that the facilities are in compliance with the Medicare conditions of participation for providers of outpatient physical therapy, occupational therapy, and speech pathology services. However, this process focuses only on whether or not the facility meets applicable health and safety standards, whether the staff is properly licensed to render therapy, and whether the existing medical records contain the required documentation. The survey is not designed to include a medical review of the clinical records to determine the appropriateness (i.e., medical necessity) of the services rendered.

Furthermore, an ORF is required to have one primary Medicare-certified location that is adequately staffed and equipped to treat patients. Our review showed that many providers have opened satellite facilities, or extension units, to render services within assisted living facilities (ALF) or skilled nursing facilities (SNF). The HCFA does not require these units to be surveyed by the State agency. In addition, there is no requirement that the originally-certified site undergo any periodic re-certification. Essentially, once an ORF is granted

participation in the Medicare program, there is minimal accountability that it - or its extension units - remain compliant with Medicare requirements.

Lastly, we believe that FI medical review activities of outpatient rehabilitation services provided by ORFs need to be expanded to identify claims for beneficiaries whose conditions were inappropriate for treatment or who would not benefit from the services.

Based on the results of our review, we recommended that HCFA:

- Consider implementing a review process for new providers to include an evaluation of whether the services provided to beneficiaries meet Medicare requirements.
- Consider a periodic re-certification requirement for ORFs to determine whether or not the facilities remain compliant with Federal and State laws and regulations.
- Instruct FIs to recover the specific overpayments we identified as part of our sample and review all other claims submitted by the ORFs for the beneficiaries in our sample to identify and recover additional overpayments.
- Require FIs to provide in-house educational services to new providers to inform them about Medicare coverage, billing, and reimbursement requirements.
- Require FIs to conduct a pre-payment medical review of claims submitted by new providers to determine the appropriateness of the services rendered.
- Require FIs to intensify medical review of claims submitted by ORFs.

In its written response to our draft report, HCFA concurred with our specific recommendations. As part of its comprehensive plan for program integrity, HCFA developed an action plan to deal with the vulnerabilities of ORFs and Comprehensive Outpatient Rehabilitation Facilities (CORF). The action plan presents both short- and long-term interventions. Short-term approaches to improve high claim error rates as well as a geographical concentration of providers, include an intensified, targeted, and progressive medical review strategy and educational interventions. An independent program safeguard contractor task order will be developed to address the problems of a lack of re-certification surveys by State agencies and the proliferation of off-site locations. Long-term activities include the use of the pending regulation that establishes and maintains provider billing privileges to more closely monitor new and existing providers and a comprehensive review of the benefit and regulations by several HCFA components.

We believe HCFA's action plan, when fully implemented, should help to ensure the integrity of Medicare payments for this benefit. The complete text of HCFA's response is presented as APPENDIX D to this report.

## INTRODUCTION

### BACKGROUND

Section 1861(p) of the Social Security Act (Act) defines outpatient physical therapy services as "...physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency...to an individual as an outpatient." A rehabilitation agency is defined in section 120 of the HCFA Outpatient Physical Therapy and CORF Manual (the Manual) as a provider of outpatient physical therapy, occupational therapy, and/or speech pathology services. In recent years, the term "rehabilitation agency" has become synonymous with "outpatient rehabilitation facility" or ORF in the Medicare provider community.

Section 1861 of the Act also includes a provision that the outpatient therapy services may be rendered at a facility (such as an ORF), a physical therapist's office, or an individual's home. Although there is no requirement that services be rendered on the ORF premises, providers must maintain a centralized location with adequate space, equipment, and staff to treat patients.

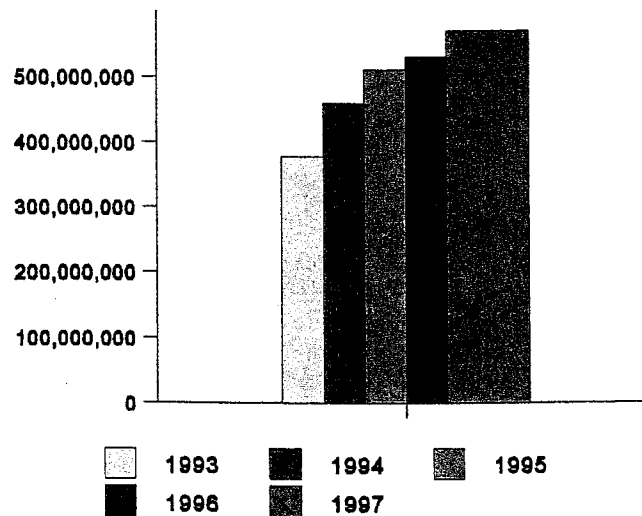
Medicare covers outpatient physical therapy, occupational therapy, and speech pathology services rendered in an ORF setting. The conditions for coverage of ORF services are outlined in sections 270 through 273 of the Manual. These guidelines state that the services must be reasonable and necessary to treat an individual's illness or injury. There must be an expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time, and the services must relate directly to the treatment goals. In addition, the services must be at a level of complexity and sophistication that they can be safely and effectively rendered *only* by (or under the supervision of) a skilled therapist.

Medicare requires the ORF to demonstrate that the services were: (1) required for the patient; (2) furnished under a treatment plan that has been reviewed by a physician; and (3) furnished while the patient was under the continuous care of a physician. A patient receiving ORF services must be seen by a physician every 30 days, and documentation of the visit must be maintained in the medical record.



Over the past several years, Medicare payments for ORF services have increased substantially. Total Medicare payments to ORFs grew from \$378 million in 1993 to \$572 million in 1997.

### National Medicare Payments for ORF Services



### SCOPE AND METHODOLOGY

The objective of this review was to determine whether outpatient physical therapy, occupational therapy, and speech pathology services were provided and billed in accordance with Medicare eligibility and reimbursement requirements.

The six States selected for the review--Florida, Texas, New Jersey, Pennsylvania, Louisiana, and Michigan--were selected from the HCFA Customer Information System data because of their high Medicare reimbursement for ORF services as compared to the remainder of the States. In CY 1997, Medicare reimbursed a total of \$572 million to all ORF providers nationwide. Of this amount, providers in Florida, Texas, New Jersey, Pennsylvania, Louisiana, and Michigan received \$277 million, approximately 50 percent of the total.

Our sample was selected from the universe of claims paid by FIs servicing the six States for the period of July 1, 1997 through June 30, 1998. For the 12-month period, the FIs paid 511,054 ORF claims totaling \$262,640,089 for the six States. Our sample consisted of 200 claims paid for services rendered to 200 Medicare beneficiaries. The value of our

sample was \$119,858. APPENDIX A contains the details of our sampling methodology. APPENDIX B contains the results and projections of our sample.

To determine whether the services rendered to beneficiaries were in accordance with Medicare eligibility and reimbursement requirements, we obtained the supporting medical record documentation for 192 of the 200 sample claims and submitted it to FI medical review experts. We were unable to review the remaining eight claims from eight providers because the providers were either suspended or terminated from the Medicare program, unable to produce any medical record for the beneficiary, or no longer operational and could not be located. Although we could not complete our review of these claims, six of these providers were either suspended or terminated from the Medicare program or were unable to produce any medical record for the beneficiary. In accordance with our sampling methodology, the claims from these six providers were considered errors. The claims from the other two providers, which were no longer operational or could not be located, were not considered errors.

We did not review the ORFs' internal control structures or their cost reports. However, for each ORF contacted, we interviewed the principals to obtain information related to marketing strategies, the beneficiary admission process, and sources of patient referrals. We also conducted personal interviews with selected beneficiaries (or a close relative/acquaintance) to learn about their medical histories and circumstances surrounding their admission to the ORF.

Our audit was conducted in accordance with generally accepted government auditing standards. The field work was conducted in Florida, Louisiana, Michigan, New Jersey, Pennsylvania, and Texas. We visited the ORFs' primary facilities (or administrative offices) and selected beneficiaries' places of residence. The field work was conducted from January 1999 to September 1999.

## **RESULTS OF REVIEW**

We estimate that, for the 12-month period ended June 30, 1998, Medicare FIs paid ORFs in the six States reviewed \$173 million for unallowable or highly questionable ORF services. During this period, a total of \$263 million was paid for ORF services in these six States. The ORFs in these six States received about 50 percent of all Medicare ORF payments nationwide during CY 1997.

From the ORFs in the 6 States, we statistically selected for review 200 claims containing 1,475 units of physical therapy, occupational therapy, and speech pathology services. Of these, 108 claims (54 percent) containing 843 units of service (54.7 percent of the services) were found to involve unallowable or highly questionable services.

Of the 200 claims statistically selected, we medically reviewed 192 claims containing 1,397 units of service and found that 102 claims containing 782 units did not meet Medicare requirements. The unallowable services were not medically necessary for the patients' conditions and/or not documented in accordance with Medicare requirements. Another 78 units of service contained on 8 claims from 8 providers were not reviewed because the providers were either suspended or terminated from the Medicare program, unable to produce any medical record for the beneficiary, or no longer operational and could not be located. Although we could not complete our review of these claims, six of these providers were either suspended or terminated from the Medicare program or were unable to produce any medical record for the beneficiary. In accordance with our sampling methodology, the claims from these six providers were considered errors. The claims from the other two providers, which were no longer operational or could not be located, were not considered errors.

### *Services Not Reasonable and Necessary*

Our review showed that 567 units of service contained in 66 claims were for services that were not reasonable and necessary for the patients' conditions. The conditions for coverage of outpatient physical therapy, occupational therapy, and speech pathology services state that to be covered, therapy services must be: (1) a specific and effective treatment for the patient's illness or injury; (2) at a level of complexity and sophistication that they can be safely and effectively rendered **only** by (or under the supervision of) a skilled therapist; (3) expected to improve significantly the patient's condition within a reasonable and predictable period of time; (4) provided in accordance with a physician-approved treatment plan; and (5) reasonable with respect to the treatment goals (i.e., amount, frequency, and duration).

Specific medical review findings included:

- Evidence did not show that the therapy services provided were an effective treatment for the patient's illness or injury.
- Patients had achieved their restorative potential and were provided non-skilled repetitive exercises.
- Patients did not require the care of skilled therapists.

Medical reviewers concluded that 66 claims containing 567 units of service were not reasonable and necessary for the conditions of the patients. The reviewers' decisions were based on the fact that the services were either provided to beneficiaries who: did not have a loss of functioning or a functional limitation; had no potential for significant improvement; did not require the specialized care of a skilled therapist; and/or were receiving non-skilled modalities and repetitive exercises (maintenance therapy).

Examples of beneficiaries who received services that did not require the services of a skilled physical therapist are presented in APPENDIX C.

### ***Inadequate Documentation***

Our review showed that 215 units of service contained in 36 claims lacked adequate documentation to justify Medicare reimbursement. Medicare guidelines require the ORF to demonstrate that the services were: (1) required by the patient; (2) furnished under a treatment plan that has been reviewed or established by a physician; and (3) furnished while the patient was under the continuous care of a physician. A patient receiving ORF services must be seen by a physician every 30 days, and documentation of the visit must be maintained in the medical record. Medicare regulations state that no payment may be made for outpatient physical therapy, occupational therapy, or speech pathology services unless a physician certifies that the services were medically necessary to treat the individual's condition.

Section 1833(e) of the Act states that documentation must be provided to support that the services were rendered. Section 1833(e) of the Act and 42 CFR Part 424.5(a)(6) places a requirement upon the provider to furnish such documentation as may be necessary to support the Medicare payments.

The FI medical experts determined that 36 claims containing 215 units of services were inadequately documented. Many records were missing required documentation such as a treatment plan, the physician authorization for services, initial evaluation forms, or documentation of the patient's prior level of functioning.

In addition, several records did not support the charge for treatment. Examples included: (1) the documentation indicated the provision of speech pathology services although the provider billed for occupational therapy services; (2) the record contained only weekly summaries which did not include sufficient documentation to support the claimed services; (3) the documentation failed to establish the relation of the therapy to the treatment goals; and (4) the medical record lacked evidence of physician authorization and supervision.

## **CONCLUSIONS AND RECOMMENDATIONS**

We believe that Medicare made payments to ORFs for unallowable or highly questionable services because, in part, there was no review process for new ORF providers which included an evaluation of whether the services provided to beneficiaries met Medicare requirements. The HCFA contracts with each State's survey agency to conduct an on-site survey of ORFs which submit an application to be a Medicare provider. If approved, the

applicant is issued a Medicare provider number. The intent of the survey is to ensure that the facilities are in compliance with the Medicare conditions of participation for providers of outpatient physical therapy, occupational therapy, and speech pathology services. However, this process focuses only on whether or not the facility meets applicable health and safety standards, whether the staff is properly licensed to render therapy, and whether the existing medical records contain the required documentation. The survey is not designed to include a medical review of the clinical records to determine the appropriateness (i.e., medical necessity) of the services rendered.

Furthermore, an ORF is required to have one primary Medicare-certified location that is adequately staffed and equipped to treat patients. Our review showed that many providers opened satellite facilities, or extension units, to render services within ALFs or SNFs. The HCFA does not require these units to be surveyed by the State agency. In addition, there is no requirement that the originally-certified site undergo any periodic re-certifications. Essentially, once an ORF is granted participation in the Medicare program, there is minimal accountability that it - or its extension units - remain compliant with Medicare requirements.

Lastly, we believe that FI medical review activities of outpatient rehabilitation services, provided by ORFs, need to be expanded to identify claims for beneficiaries whose conditions were inappropriate for treatment or who would not benefit from the services.

Based on the results of our review, we recommended that HCFA:

- Consider implementing a review process for new providers to include an evaluation of whether the services provided to beneficiaries meet Medicare requirements.
- Consider a periodic re-certification requirement for ORFs to determine whether or not the facilities remain compliant with Federal and State laws and regulations.
- Instruct FIs to recover the specific overpayments we identified as part of our sample and review all other claims submitted by the ORFs for the beneficiaries in our sample to identify and recover additional overpayments.
- Require FIs to provide in-house educational services to new providers to inform them about Medicare coverage, billing, and reimbursement requirements.
- Require FIs to conduct a pre-payment medical review of claims submitted by new providers to determine the appropriateness of the services rendered.

- Require FIs to intensify medical review of claims submitted by ORFs.

In its written response to our draft report, HCFA concurred with our specific recommendations. The HCFA stated that it has been aware of the potential for abuse in the provision of therapy services in CORFs and ORFs and has taken steps to reduce Medicare vulnerability. Currently, many HCFA contractors place new therapy providers on some level of intensified review, and therapy providers have been included in special focus reviews for several years.

As part of its comprehensive plan for program integrity, HCFA developed an action plan to deal with the vulnerabilities of ORFs and CORFs. The action plan presents both short- and long-term interventions. Short-term approaches to improve high claim error rates as well as a geographical concentration of providers, include an intensified, targeted, and progressive medical review strategy and educational interventions. An independent program safeguard contractor task order will be developed to address the problems of a lack of re-certification surveys by State agencies and the proliferation of off-site locations. Long-term activities include the use of the pending regulation that establishes and maintains provider billing privileges to more closely monitor new and existing providers and a comprehensive review of the benefit and regulations by several HCFA components.

We believe HCFA's action plan, when fully implemented, should help to ensure the integrity of Medicare payments for this benefit. The complete text of HCFA's response is presented as APPENDIX D to this report.

## SAMPLING METHODOLOGY

### OBJECTIVE

To determine whether the payments for ORF services met the Medicare eligibility and reimbursement requirements.

### POPULATION

We used the universe of paid ORF claims in Florida, Texas, Louisiana, Michigan, New Jersey, and Pennsylvania for the period July 1, 1997 through June 30, 1998.

The universe consisted of the following data:

Total ICN Numbers (claims):	511,054
Total Billed:	\$456,907,717.77
Total Reimbursed:	\$262,640,088.74

### SAMPLE UNIT

The sample unit was a paid ORF claim for a Medicare beneficiary. A paid claim includes multiple units of outpatient physical therapy, occupational therapy, and/or speech pathology services claimed by a provider for the period of time covered by the claim.

### SAMPLE DESIGN

An unrestricted random sample of paid claims (greater than zero) was used.

### SAMPLE SIZE

The sample size was 200 claims.

### ESTIMATION METHODOLOGY

Using the RAT-STATS Variable Appraisal Program, we projected the amount of Medicare reimbursement for ORF claims in the six States that did not meet the Medicare eligibility and reimbursement requirements.

Using the RAT-STATS Attribute Appraisal Programs, we projected the percentage of claims in the six States that did not meet the Medicare eligibility and reimbursement requirements.

Using the RAT-STATS Attribute Appraisal Programs, we projected the percentage of units of service in the six States that did not meet the Medicare eligibility and reimbursement requirements. The percentage of units was calculated using cluster methodology, where a claim represents a cluster of units of service.

## PROJECTIONS

**RESULTS OF SAMPLE:**

<u>Number of Claims in Sample</u>	<u>Value of Sample</u>	<u>Number of Claims in Error</u>	<u>Value of Errors</u>	<u>Number of Units in Sample</u>	<u>Number of Units in Error</u>
200	\$119,857.84	108	\$67,803.98	1475	843

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**Variable Projections**

Errors Identified in the Sample:	108
Value of Errors in the Sample:	\$67,803.98
<b>Point Estimate:</b>	<b>\$173,257,476</b>
At the 90% Confidence Level:	
Lower Limit:	\$130,466,735
Upper Limit:	\$216,048,217

**Attribute Projections for Claims:**

Claims in Sample:	200
Number of Claims in Error:	108
<b>Point Estimate of Error Rate:</b>	<b>54.0%</b>
Projected Error Rate at 90% Confidence Level:	
Lower Limit:	47.9%
Upper Limit:	60.0%

**Attribute Projections for Units of Service:**

Units of Service in Sample:	1475
Number of Units of Service in Error:	843
<b>Point Estimate of Error Rate:</b>	<b>54.7%</b>
Projected Error Rate at 90% Confidence Level:	
Lower Limit:	48.1%
Upper Limit:	61.3%



## EXAMPLES

### EXAMPLE 1

An 82 year-old woman who resided independently and suffered from osteoporosis with a history of lumbar fractures, received a prescription from her physician for an evaluation by a physical therapist. The physician wrote a prescription for “evaluation only - patient needs access to a pool.” The beneficiary had previously undergone rehabilitative treatment after the lumbar fracture. Her recent history indicated extensive aquatic rehabilitation. The beneficiary wanted use of a pool.

The facility’s evaluation proved that the beneficiary’s range of motion was within functional limits, and the strength of her lower extremities was good. The beneficiary stated that while at the facility she walked and floated in the pool unsupervised.

The medical review determined that the services were not covered because physical therapy was not reasonable and necessary. The patient’s condition did not require treatment by a qualified physical therapist. The medical record did not support the charge for treatment. There was no documentation to support that any treatment was actually rendered by a qualified physical therapist.

### EXAMPLE 2

A 51 year-old man who injured his back over 10 years ago and has been on disability since the injury, was provided physical therapy services. The medical documentation revealed that the patient had no surgeries or physical therapy services since the initial injury. Goals selected for the patient by the physical therapist included: (1) get in shape and (2) be fit and do it safely.

The medical review denial decision states “services related to activities for the general good and welfare of beneficiaries, such as exercises promoting general fitness and flexibility, and diversion or motivating activities do not constitute physical therapy services for Medicare purposes.” The services do not meet medical necessity requirements to support continued services by a qualified physical therapist.



DEPARTMENT OF HEALTH & HUMAN SERVICES

PAGE 1 OF 5

Health Care Financing Administration

The Administrator  
Washington, D.C. 20201

**DATE:** FEB 24 2000

**TO:** June Gibbs Brown  
Inspector General

**FROM:** Nancy-Ann Min DeParle *Nancy-Ann DeParle*  
Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: "Six-State  
Review of Outpatient Rehabilitation Facilities"  
(A-04-99-01193)

Thank you for the opportunity to review the above-referenced report concerning the six-state review of outpatient rehabilitation facilities (ORFs).

HCFA has been aware of the potential for abuse in the provision of therapy services in Comprehensive Outpatient Rehabilitation Facilities (CORFs) and ORFs and has taken steps to reduce Medicare vulnerability. Currently, many of our contractors place new therapy providers on some level of intensified review, and therapy providers have been included in special focus reviews for several years. For example, in 1999 HCFA's Miami Satellite Office initiated six in-depth, on-site facility reviews in Florida, partnering with the OIG, HCFA's contractors and the Florida state agency. These reviews uncovered multiple problems, including providers that failed to meet certification requirements; a claims error rate of approximately 80 percent; and more than one million dollars in disallowed cost report expenses.

As part of its comprehensive plan for program integrity, HCFA developed an action plan to deal with the vulnerabilities of CORFs and ORFs. HCFA's plan is to resolve the issues addressed in the draft report. The action plan presents both short and long-term interventions. Short-term approaches to improve high claim error rates (which include services not medically reasonable and necessary, and poor documentation), as well as a geographical concentration of providers, include an intensified, targeted, and progressive medical review strategy and educational interventions. An independent program safeguard contractor task order will be developed to address the problems of a lack of recertification surveys by state agencies and the proliferation of off-site locations. Long-term activities include the use of the pending regulation that establishes and maintains provider billing privileges to more closely monitor new and existing providers and a

Page 2 - June Gibbs Brown

comprehensive review of the benefit and regulations by several HCFA components.

We are currently making contract decisions to determine how much of this work will be carried out by fiscal intermediaries (FIs) or special Medicare Integrity Program (MIP) contractors.

The Health Care Financing Administration (HCFA) concurs with the OIG recommendations. Our specific comments follow:

OIG Recommendation

HCFA should implement a review process for new providers to include an evaluation of whether the services provided to beneficiaries meet Medicare requirements.

HCFA Response

We concur with this recommendation. Currently many FIs place new ORF providers on some level of medical review. HCFA's plan includes analysis of therapy claims data, and development and implementation of medical review strategies, which will include new providers.

OIG Recommendation

HCFA should consider a re-certification requirement for ORFs to determine whether or not the facilities remain compliant with Federal and state laws and regulations.

HCFA Response

We concur. HCFA will consider a re-certification requirement for ORFs to determine if facilities remain compliant with Federal and state laws and regulations.

OIG Recommendation

HCFA should instruct FIs to recover the specific overpayments identified as part of the sample and review all other claims submitted by the ORFs for the beneficiaries in the sample to identify and recover additional overpayment.

HCFA Response

We concur with the recommendation for recoupment of identified overpayments to the extent feasible under statutory limitations such as time frames regarding reopenings. HCFA will encourage the FIs to review all ORF claims for the beneficiaries in the sample.

Page 3 – June Gibbs Brown

OIG Recommendation

HCFA should require FIs to provide in-house educational services to new providers to inform them about Medicare coverage, billing, and reimbursement requirements.

HCFA Response

We concur with the idea of increased provider education. To provide a better understanding of the Medicare rehabilitation benefit and coverage programs, HCFA plans to provide benefit education to FIs, regional offices, and state agencies. In addition, several FIs have submitted provider rehabilitation projects as part of Operation Restore Trust for fiscal year 2000.

OIG Recommendation

HCFA should require FIs to conduct pre-payment medical reviews of claims submitted by new providers to determine the appropriateness of the services related.

HCFA Response

We concur. As noted in the HCFA plan, we will develop and initiate progressive, intensified medical review for therapy providers. This strategy will include all types of review determined to be effective, including pre-pay, post-pay and focused review.

OIG Recommendation

HCFA should require FIs to intensify medical review of claims submitted by ORFs.

HCFA Response

We concur. HCFA has determined that 50 percent of all ORF claims were paid in six states. Therefore, a targeted approach to medical review is most effective. The focus of this approach will be determined by the development of the progressive intensified medical review strategy previously mentioned.

Technical Comments

The shaded "box" on page one of the draft report states "Medicare paid \$173 million for unallowable and highly questionable rehabilitation services." We believe that the statement to be accurate, should read, "The OIG estimates that Medicare paid \$173 million for unallowable or highly questionable rehabilitation services."

**ACTION PLAN  
CORFs/ORFs**

**SHORT - TERM ACTIONS**

**1- PSC TASK ORDER**

Issue a PSC task order for a contractor to develop and implement a strategy for intensified review of therapy services based on analysis of claims data. The recent BBRA contains provisions for suspension of therapy limits and focused medical review of therapy services.

Responsible Component- OFM

**PROBLEMS ADDRESSED:**

High claims payment error rate  
BBRA provisions requiring suspension of payment limits  
BBRA provision requiring focused review of therapy services

**2- EDUCATION**

Benefit training will be provided to Regional Offices, Fiscal Intermediaries, State Agencies and other stakeholders as identified.

Responsible Components - OFM/ CMSO/CHPP

**PROBLEMS ADDRESSED:**

High claims payment error rates  
Misunderstanding of the benefit  
Poor documentation

**3- DETERMINE FEASIBILITY OF LIMITING OFF-SITE LOCATIONS**

Responsible component- OGC

**PROBLEMS ADDRESSED:**

Proliferation of extension units  
No review of off-site locations  
Lack of State Agency surveys

## LONG-TERM ACTIONS

## 1 - PROVIDER ENROLLMENT

Proposed rule to be published in early 2000. Will provide increased scrutiny for providers not subject to State laws.

Responsible component- OFM/PI/DPSE

**PROBLEMS ADDRESSED:**

**Lack of state oversight**  
**Proliferation of off-site locations**

## 2 - REGULATORY CHANGE RECOMMENDATIONS

### Comprehensive review of the regulations and recommendations for changes

Responsible component- CHPP/OL/OCSQ

**PROBLEMS ADDRESSED:**

Off-site locations  
Clarification of types of rehabilitation providers  
Review of Conditions of Participation